



Service Priorities and Programmes
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Enhanced Diabetes Mellitus Program in the community

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Introduction

Diabetes Mellitus (DM) is one of most common worldwide chronic diseases that could lead to major health problems and complications. Although United Christian Hospital (UCH) Community Nursing Service (CNS) provides enhanced diabetic nursing care for the diabetes patients referred from various specialties, the consistent clinical support is still fragmented. According to data in 2016/17, there are 136 patients under enhanced diabetic care. There were 43 frequencies of attendance in Accident and Emergency Department (AED) due to unstable glycemetic control. In order to strengthen the magnitude of clinical support, Enhanced Diabetes Mellitus (EDM) Program with supported by endocrine team has been established for brittle diabetes patients who were suffering from unstable glycemetic control; require more intensive glycemetic monitoring, management and empowerment.

Objectives

1. To strengthen the diabetes care in the community 2. To improve and stabilize glycemetic and other metabolic control 3. To reduce emergency attendance

Methodology

This program was launched in August 2017 in UCH CNS. Recruited patients are exposed to brittle diabetic control with complications referred from diabetes nurses or community nurses (CNs). In this program, it offers seamless care to recruited patients by providing timely, low-barrier access to a network of endocrine team in term of fast-track clinic and regular case conference. Intensive diabetic nursing care under an agreed care protocol was developed. Intervention carried out by CNs includes diabetic thorough assessment, self-management education; patients' engagement on life-style modification and discussion with endocrine team on treatment plan. Descriptive data of patients demographics, glycemetic control (HbA1c), frequency of emergency attendance and empowerment score (a set of Key Performance Indicators for evaluating the effectiveness of community nurses in chronic disease home care management) were analyzed.

Result

Result From August to December 2017, six patients with mean age 74 were recruited in this program. The majority of referral reasons were brittle diabetic control. There were 84% and 16% referred from Endocrine Team and CNS respectively. The average number of fast-track clinic was 2.2 frequencies per case for avoidance of emergency attendance. During the period of the program, we were able to avoid all recruited patients for emergency attendance. There was a significant improvement in HbA1c with pre and post values of 8.8% and 7.6% ($p < 0.05$). Moreover, the overall empowerment score was improved by 20.8% ($p < 0.01$) for disease knowledge and self-care. Conclusion This program enhanced standardization of care and quality, makes good use of diabetic specialists, to involve care plans and close performance monitoring. It also facilitates the smooth transition of diabetic patients from acute to community with better clinical support, thus improving patients' conditions and empowerment.